Kathleen Feeney – Southwestern Vermont Council on Aging Case Manager

Hi Joan,

I had a couple of questions on the 1115 waiver. Pages 10 and 18 discuss the limit on Medicaid resources to be allowed for the enrollee. The resource is deemed to the enrollee but there is no mention of a spouse and the current resource limit allowed the non-waiver spouse. At this time the non-waiver spouse is allowed to keep $90,000+, excluding the house. Is this to be terminated? If so, many couples will not be eligible for the waiver.

***No changes will be made to this part of the long-term care program.***

Also. If the enrollee is allowed to keep above the $2,000 limit, will the amount allowed to this person be considered a part of the spouse's resource or will it be a separate resource amount deemed only for the enrollee?

Or, is this section discussing the enrollee as someone without a spouse and therefore this question is mute.

***We will allow the enrollee to keep up to the $10,000 resource limit and this will be separate from the spouse's or civil union partner's resource allocation.***

Will the current policy for Spousal Allotment for income change?

***We will maintain the same spousal income protections that exist today.***

The draft of the 1115 Waiver seems to describe only the single person or are we to assume that the current policies that arrange finances for the spouse will remain in place?

***The current policies will remain in place; however, we will be looking out for those unintended consequences.***

I ask this because my experience this year with the Medicaid and Medigap insurance and the pharmacy program made me very aware of what happens to the client when crucial wording is not included in policies and the client finds that he/she is not eligible for coverage for insurance.

Pg. 11 Third paragraph

This discusses services for the High and Moderate Need group. It states that the enrollee will receive a partial service plan coupled with other services available in the community outside the waiver. Examples of outside services are listed. One of these outside services is case management according to this paragraph. On page 7 the sentence in the description of the services for these same subgroups states: This might be as little as a weekly homemaker visit, or a monthly case management visit. On page 13 the sentences read: All Demonstration enrollees, including those in the Enhancement Group, will be eligible for case management services. The enrollees who are being served, but perhaps not to the full extent of their needs, will also be directed to other community-based resources.

On page 14 under monitoring the sentence states:

For individuals residing at home or in a foster family care home, certified case managers will meet, face-to-face, with each Demonstration enrollee at least monthly.

IF THE CASE MANAGER IS AN OUTSIDE SERVICE, HOW CAN THIS HAPPEN AS A WAIVER SERVICE?

***The draft states that "Individuals enrolled in the Demonstration as members in the High and Moderate Need group will receive long-term care services only up to the level that can be funded through***

***available resources." We expect case managers to utilize community-based resources whenever possible.***

***As far as payment for case management services is concerned, we must ensure that we do not use the 1115 waiver funds to supplant or duplicate case management services paid for by other sources such as the Older Americans Act. We still need to work through the details on how we would accomplish that.***

Last but not least:

Residential Care facilities:

If the case management services is eliminated from the enrollee residing in one of these, who will be the objective monthly visitor.

***We are still collecting comments on whether or not to include case management as a service for residents in the Enhanced Residential Care program. If you have ideas, we would like to hear them.***

The RCH does not have the funds to employ someone to do the paperwork involved in the waiver. They may just decide to not be a part of the program and thus force some clients to choose a nursing facility when they cannot remain in the community under the waiver. Small RCH facilities just cannot afford to assume the paperwork, etc. that goes with this program.

The ACCS program. This will continue as is? The RCH can bill for ACCS in addition to ERC payments as separate Medicaid programs? If this is discontinued the RCH facilities stand to lose a considerable amount of income and those now doing the ERC here may question their participation in the program.

***Yes, the ACCS program will continue as is as a Medicaid State Plan service. The ERC providers would continue to bill for the ACCS program as well as ERC services.***

Thanks for listening to my questions. Feel free to contact me if I am not clear in my questions.

Kathleen Feeney, SVCOA